A PSYCHIATRIC SOCIAL WORKER OVERSEAS

IRENE TOBIAS
American Red Cross

FAMILY WELFARE ASSOCIATION OF AMERICA

A PSYCHIATRIC SOCIAL WORKER OVERSEAS

Service in the American Red Cross

by

Irene Tobias

I. In a General Hospital during the Tunisian Campaign

II. In a Neuropsychiatric Hospital

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I.

IN A GENERAL HOSPITAL DURING THE TUNISIAN CAMPAIGN

THIS IS A RECORD of impressions of the professional experiences of one social worker sent overseas by the American Red Cross. I plan to tell of the services that I myself found possible to give, functioning as part of a Red Cross Unit in military hospitals with the American Army. It is probable that every experience with an army hospital overseas is unique. The worker's experiences are fashioned by the function of the hospital, that is, whether it is a general one or specialized; by its place in the theater of operations, whether it is a field hospital just behind the combat lines or a base hospital hundreds of miles to the rear. Her experiences are also fashioned by the uses the hospital staff wish to make of the worker and by the limitations of the physical setup. Experiences and functions in one hospital may bear little rememblance to those in another hospital. I plan to tell of my work in two military hospitals, both located, at the time I was with them, in North Africa.

I was sent overseas as a part of a Red Cross Unit attached to a general hospital. I worked with this hospital for a six-month period when it was operating near the theater of combat, from the end of April until November, 1943. When this hospital was about to be moved to another theater of operations I was transferred to a psychiatric hospital in a base area, many hundreds of miles to the rear. Except for the one important common function of helping a soldier communicate with his family, my activities in the one hospital differed greatly from those in the other.

I have selected details that have remained most vivid to me, incidents that are most typical of what I did, and those that I thought would be of most interest to other social workers. The material is largely from memory, since no case records are available this side

of the water. However, to refresh my memory, I have copies of a few interviews done in the psychiatric hospital and of monthly summaries prepared for the Red Cross Regional Office from both hospitals.

The Hospital

I was sent overseas as part of a Red Cross Unit composed of two social workers, two recreation workers, and a secretary. The hospital to which I was attached was a large one, designated as a general hospital but actually functioning at the beginning as an evacuation hospital, set up in the Tunisian Hills just before the last offensive that ended the Tunisian campaign. Ours was the only general hospital this near the front and it received casualties directly from the field hospitals set up just behind the battle lines. Later, during the Sicilian and Italian campaigns, we received casualties through a nearby port and airfield, sometimes within a week of the time they were taken out of battle. Patients arrived by ambulance convoys and by hospital trains. They arrived frequently by hundreds and were evacuated by hundreds. The length of time the hospital was permitted to keep a patient varied from 10 to 90 days. It was usually a 30-day period. That meant that any patient who was not expected to be able to return to duty within this time was sent out on the first possible evacuation train if his condition permitted travel. During periods in the middle of a campaign patients would come in at the rate of 200 a day and be evacuated the next day. Then they became just a blur of faces; we never got to know them. However, during lulls in campaigns patients remained longer and we could become acquainted with them as individuals.

When I started to write this account I found that I was unable to write entirely in the usual technical language. The experience was a deeply emotional one for me, and if I am to present it accurately I must express some of that emotion. I question whether one could really participate in this experience sufficiently to have a healing relationship with these men without being emotionally moved oneself.

Ours was a tent hospital. When we arrived at the location chosen by the army there was only a cluster of small tents on a hillside for housing the staff. Below us was a flat Arab pea field, and day by day we watched the army engineers put up our hospital there—row on

row of ward tents—and listened to the noise of the concrete mixers, hammers, and saws. Beyond and encircling us was a green mountain valley, carpeted with luxuriant wheat and pastures of vivid flowers. We were cut off from any sight or sound of combat except for the fleets of planes that passed overhead. Assigned to the Red Cross were two large ward-size tents for recreation purposes and a little wall tent for the two social workers. This tent was just large enough for two tables, at which we sat back to back, a large chest for comfort supplies, and a chair for patients at the side of each table. There was never any guarantee of privacy, of course, for interviews. The tent flaps had to be rolled up front and back for air and light, and patients gathered at both ends listening to interviews, frequently interrupting with suggestions or viewpoints of their own. It was only in the evenings that it was possible to have interviews of more than a few minutes with a soldier alone, and my schedule was arranged to suit these circumstances. The beds in the wards were so close together that no privacy was possible there.

During the weeks in which our hospital was being built the Red Cross staff was busy setting up its own equipment. Furniture for the recreation rooms had to be built out of packing boxes, and paint found in a nearby city. A good deal of the painting we did ourselves. The library had to be catalogued, comfort supplies unpacked, inventories made, a record system set up, and recreation kits distributed to all the wards.

Common Needs

What are the common needs of the soldier patients arriving in such a setting which can be met by a social worker with the American Red Cross? The function performed may or may not be considered case work. However, it is my belief that the training of the social worker makes her better able to understand the common needs of these men returning from the battle lines and makes possible a more careful selectivity of activity and a more economical and fuller use of her opportunities.

I found the existence of some anxiety in battle casualties very common, at least during the first few weeks of their hospitalization, whether they were surgical or psychiatric cases or whether they had been removed from the front lines for medical reasons. These men

had just come from an environment that lacked every physical comfort, where the necessities of life—food, water, shelter, and sleep—were difficult to secure, and where life itself was threatened night and day by enemy action. It was a cruel, hostile environment. The natural, libidinal support in such a situation—the presence of one's comrades and commanding officers who had become family substitutes in the months and years of living and training with a company—had been taken away when the man was removed from battle. Or worse still, he had lost them when they had been killed before his eyes. Over and over again men were reacting emotionally to an incident of traumatic bereavement.

Their sense of isolation was deepened more often than not by lack of letters from home for many weeks or even months. Before going into battle, the company frequently made many moves that delayed the mail from coming through. There was even greater delay where the man had to be traced by the army post office through a chain of hospital evacuations, from his outfit to the field hospital, to the station hospital, and then from the general hospital in one theater to a general hospital in another. Although the army made the most strenuous efforts to get mail through, each one of these steps usually took at least a week, and mail often was delayed for months. Moreover, when men arrived at the hospital they had usually lost or left behind all money and possessions. They became separated from the tokens of libidinal ties at home, such as letters and pictures of family or sweetheart, and lost whatever security they might find in possessing money. Their anxiety and sense of isolation were heightened by the long line of evacuation from hospital to hospital. Frequently they stayed in one hospital only overnight to be moved on to the next and the next, enduring the fatigue of travel under war conditions. Over and over they would express the hope that they were going to be allowed to stay in our hospital long enough to become friends with their ward mates, and to get to know the nurses, doctors, and Red Cross staff. The need to be allowed to develop again some human relationships was intense. And, of course, all these emotional needs were piled on top of those usually present in any illness or injury.

Under these circumstances anything we did for these men—any simple word of greeting, any small concrete service—had a meaning

and significance beyond anything it would have in any other setting. I was made even more deeply aware of this long after I left this hospital. With hundreds coming in every day the patients became only a blur of faces. It was only occasionally that one of them became an individual for me so that I could remember name or face. But not so with the soldier. After I left this hospital, wherever I went in North Africa, and even after my return to a military hospital in the States, again and again some soldier would rush up to me and, with the most evident pleasure, recall that he had known me in this hospital and stop to exchange reminiscences. I found myself developing a technique for recalling at least some association with the soldier. By learning when he had been in the hospital and in what ward, I could associate him with a doctor, with others in the ward, or with some event in our Red Cross program in order to preserve for the soldier the sense of relationship he had found with me there. Sometimes this took some quick thinking. I found that overseas I was never off duty, that I could not discard my professional function like a work-apron even on my rare day off when strolling down the street.

Finding a Friendly World

A good part of the social worker's activity in this situation was helping to restore to these men the conviction that they were once again in a friendly world, and to repair for them some thread of the relationships to their families. Our time was largely taken up with very simple tasks, chatting briefly with the men during ward rounds, supplying cigarettes and toilet articles, sending cables inquiring about the health and welfare of their families, writing letters for those unable to write themselves, helping to get their mail through, shopping for gifts for their families, and doing the small concrete services that their own families would have done for them had the latter been near enough, as in civilian life, to visit.

Back home such activities would be merely expressions of kindness and good will, just something that produced a fleeting, pleasurable moment. In this setting, however, they had a meaning and value far beyond what they would have if the soldier were living in the usual comforts and with his family near him. Under combat conditions we know that there is a severe deprivation of some of the basic psychological drives; men are not only cut off from love and affection

but from such physical satisfactions as food and cigarettes. This deprivation is felt with particular acuteness in men with strong oral drives. We got some sense of the urgency of these needs when for several weeks the regular army supply of cigarettes ran out, and again when candy was being distributed. I have heard it said that the army places cigarettes second only to ammunition in priority of supplies. I was not, however, prepared for the reaction to our distribution of chocolate bars. Many of these men had not tasted candy, particularly chocolate bars, for many months. On the regular days that candy was distributed, I was reminded of men suddenly discovering an oasis in a desert. What day we were distributing candy was one of the most frequent questions asked of the Red Cross workers as we passed through the rows of hospital tents on ward rounds. Men changed the day of their pass to town if it fell on candy day, asked for their candy beforehand if they were to be discharged. Soldiers just back from the combat areas would hold up a chocolate bar and just look at it as though they thought it was a mirage that they expected momentarily to vanish. Sometimes they would suck it like a lollipop to make it last. When we hear the discussion of army psychiatrists on the personality breakdowns resulting from the accumulated deprivations of all libidinal needs, the supplying of substitutes, in whatever forms possible, becomes a service of considerable weight.

There is perhaps another factor in the emotional import of this distribution of candy and cigarettes. One of the sources of acute conflict and anxiety to the American soldier, trained and educated for peace, taught to suppress his hostilities in childhood, is the necessity of killing. In the writer's experience this conflict about the activation of heretofore forbidden aggressions is one of the most suppressed, and was seen only in referred and indirect forms, but we know it must be there. Do the gifts of candy and cigarettes somehow become a symbol of friendly acceptance and reassurance? If the unleashing of the soldier's aggression has aroused a feeling that the world itself is hostile, do these gifts in the hospital represent a further reassurance that there is friendliness in this world after all?

It became evident that the Red Cross staff, in doing these small concrete services, played a symbolic role, representing, as it did, the good wishes of the folks back home. Both literally and figura-

tively we became the bridge between the soldier and the supporting home relationships. In our literal role, we sent cables and letters home by the hundred. Our symbolic role was partially verbalized by an officer to whom I spoke during routine rounds. He appeared to be asleep but as I passed he looked up at me and called me to his bedside. He had no physical wounds but he appeared to be in such a state of shock that it was an effort for him to speak at all. But he told me of a woman he had met on a train in the United States while returning from a furlough. She was on her way to Washington to join the Red Cross and take the training course there. He made an effort to identify me in some way with this woman, to make some association with women back home. After this I made a point of stopping by his bedside for a few minutes every day for a chat until he was able to be up and around.

Sensing Urgency

I found that one of the greatest values of my professional background was to be able to recognize quickly—on the wing, so to speak—in the necessarily hurried ward rounds, those men whom I could help, and to be aware of the help I could give them through the emotional role I could play for them. With the responsibility for covering wards totaling six, seven, or eight hundred men, this ability to select instantly becomes almost the *sine qua non* of the usefulness of a social worker.

One instance illustrates a kind of situation met many times and the usual way of meeting it. In the middle of one afternoon I received a note from a nurse that a patient in her ward, Sgt. Blackburn,[1] wished to see a Red Cross worker. When I saw Sgt. Blackburn on the ward, I immediately remembered him as a patient I had known three months before in a base hospital many hundred miles to the rear. On that occasion he had a flesh wound received while dragging a wounded comrade out of danger. His tank had been blown up and he hid all night on a hillside, keeping his wounded buddy alive. Then at dawn he had dragged his friend over the hill to safety under heavy fire. He was awarded the Silver Star for this deed. Sgt. Blackburn was a tank commander, 22, a blond and lanky six feet two, joking and swaggering a little, boasting of his toughness, minimizing

[1] Not his real name.

his wound so that he could get back to combat the faster. I remembered the gay farewells when he set off to rejoin his company.

That afternoon, three months later, I scarcely recognized the man, gaunt and unshaven, in obvious pain, who had come in after a wearying two-day trip. His face lit up with a smile when he saw me. He had suffered a compound fracture of the arm, his body had been peppered with shrapnel fragments, and a hole had been torn through his lung by a piece of shrapnel that had entered the front and gone through his back. His first words were to ask my help in getting his mail. He had not heard from his mother and sweetheart for over four months and he knew that he had Christmas boxes coming to him. (This was already May.) It was obvious what had happened to his mail. When he was wounded the first time, it had been sent through the chain of hospitals—from the field hospital to the base hospital, to the convalescent hospital, to the reception center, and then back to his company. He had been wounded the second time before his mail had a chance to catch up with him, and his mail had started through the hospital chain all over again. Since the request for help with mail came from at least one of every two soldiers entering the hospital, it was seldom that we could take any action, letting the mail come through regular follow-up channels. But because of Sgt. Blackburn's critical physical condition and evident anxiety I immediately consented to do what I could. Then he spoke of his suffering, made excruciating by the fact that the morphine had heightened his sensitivity and had kept him awake instead of having the usual effect.

He had to share with me immediately the experiences he had gone through. In a formation tank attack he had seen every member of his tank crew killed except himself. His driver, his best friend, who had trained with him for two years, had his head blown off before his eyes. He insisted that I take out of his box the pieces of shrapnel that had been removed from his body and handle them. He declared over and over, " I am through. I could never go back and face it again. I am through." As he talked and his anxiety and depression came out, it was evident that a good part of his libido was identified with his dead comrades, and willed to die, but that there was a healthy part that wanted to live, that was asking for the letters and parcels from home.

The ward medical officer confirmed my impression that Sgt. Blackburn's wounds were critical and that it was unlikely he would be moved from the hospital for some weeks. So letters were sent out to all the possible locations through which his mail might be passing, informing them of his present address. Sgt. Blackburn begged me to come back often and I did. I brought him his own brand of cigarettes, which was difficult to secure, and the hard candy he craved which kept his mouth moist. At first he could talk only about his war experiences. Then as he grew better he could talk about his family at home, and later was able to think constructively about his return home. He began talking about wanting to be an instructor in a training camp. Then finally his mail arrived—64 letters done up in one bundle and three Christmas boxes mailed in October. (This was late May.) The candy was stale and the cookies in crumbs, but the whole ward and I shared them with enthusiasm. After the arrival of the mail there were no longer the same anxious entreaties each time I visited for me to return soon. The anxiety and depression disappeared, in spite of a succession of operations for lung drainage and a continued critical physical condition. He did improve over many months, and I think there is little doubt that this improvement was aided by the regular receipt of letters from home and the help I was able to give to his upsurging will to live.

This acute anxiety associated with severe battle wounds and identification with comrades whose death has been witnessed was frequently found among battle casualties when they were seen shortly after removal from combat. It was the responsibility of the social worker to make rounds after every fresh convoy of wounded came in, no matter how hurried those rounds had to be, to find those who most needed her help. Because of the extreme pressure of the job, diagnostic skills were of the utmost value in the selection of spots where time should be spent. Another factor to consider was that the emotional reactions were usually situational in nature, imposed on a basically sound psychic structure; a very little help frequently produced surprising results.

Treatment Through the Group

In the situation of a hospital ward tent, with beds jammed together, and with patients who all have similar backgrounds of experience,

some kind of group therapy, however informal, is practically thrust upon the social worker. She enters a ward to find the ambulatory patients gathered around the bed patients and an animated discussion going on. Every battle is fought over and over. There are discussions of personal reactions to battle, to the army, to commanding officers, discussions on the causes and purposes of the war, and so on. I frequently entered into these discussions because I was interested in what the men had to say and often found that from my case work experience I was able to ask leading questions that might be helpful to them. Sometimes in the course of these discussions I might find myself more identified with the larger issues of the war than with immediate concern for the individual soldiers. However, helping them participate in the larger social enterprise is no contradiction to serving the welfare of each individual soldier both in the most far-reaching sense and for the immediate goal.

I should like to describe one situation because it illustrates how a social worker was able, in a group situation in the ward, to help a soldier, who had become self-centered and embittered by illnesses, to a more positive, outgoing, healthy attitude toward his environment, and possibly to help the rate of his recovery.

Three cases of poliomyelitis were brought into our isolation ward. Two of them, enlisted men, were mildly struck by the disease, remained cheerful, and co-operated completely in their efforts toward recovery. The third was a captain. Practically every muscle in his body seemed affected, and for many weeks it was not known from hour to hour whether he would live or die. Every skill of the finest in modern medicine was mobilized in that army tent, and there was never a moment night or day, for many weeks, when a nurse did not stand at his bedside. Through many hours a physiotherapist whispered into his ear that he must breathe. Even though he seemed unconscious at the time she was able to infuse into him her own will so that he could continue to live. The captain did live and very slowly began to recover. For many months, however, he was completely helpless, having to be spoon fed and never having a bowel movement without an enema. He continued to need almost constant treatment involved in the packing of first one set of muscles and then another set, massaging, lamp treatment, and so on. As he began to regain strength, he became extremely irritable and demanding of attention, and there was strong reason to believe that he

was not doing as much for himself as he might. The psychological progress from the condition of extreme regression was not keeping up with physical progress.

It was only when the captain was well on his way to recovery that there was actually any service the social worker could perform for him. The first offer was to write letters for him to his wife at home. (Through the period of his illness his family received regular official bulletins through the War Department, as is done in all cases of critical illness.) He had especially requested me not to write letters supplementing these bulletins, as we did in many cases, until he was able to dictate himself exactly what he wanted said. Between the dictation of sentences the captain told me about his family and, over and over, in considerable detail, came back to his rapid rise in business in the civilian world where he became the head of a very large business before being called into the army. In his talks with me it was evident that he was struggling with his present feelings of helplessness and that his ordering about of nurses and ward men was a part of his effort to gain a sense of adequacy. During his dictation to me he would suddenly change from an easy social tone to a brusque business one and would give detailed instructions about the addressing and mailing of the letters. However, his general mood remained one of bitterness, and he railed against the " filthiness " of a country in which this particular disease could be contracted. He was despondent, believing that he would never recover sufficient use of his limbs to be able to return to his former successful place in the business world. He was caustic about all who took care of him. He was certainly not making the effort that he could to take care of his bedside needs.

About this time a newcomer entered the contagion ward and was placed in the far corner cubicle. It was a German prisoner, whom we called Herr Sprengel, mortally ill with far-advanced tuberculosis. Of course, Herr Sprengel required constant care. To the captain he was not only an enemy but a threat to the captain's status as a favored patient. The captain remarked with irony, " My throat can become parched, but Schickelgruber has only to murmur ' wasser ' and two ward boys and three nurses run to his side." There were constant caustic comments made to the social worker about having to live in the same ward as Schickelgruber. The German did not understand English, but he did understand the tone of voice and the

name he was called, and his unhappiness was evident by the expression on his face.

I had become acquainted with Herr Sprengel through one of the nurses who spoke fluent German. He was very young, probably about twenty, with flaxen hair and blue eyes, and an oval handsome face. I had asked if he wished help in writing a letter home and learned that he had no one to write to. He had two brothers on the Russian front and he supposed they were dead. His mother had died young of "lung trouble." He had only a sister-in-law, but he did not know her very well. Incidentally, through the nurse, I learned that the Nazi ideology was abhorrent to him, that he had gone into the army only because he had been forced to. There was very little that I could do for him. At his request a German Bible was found and we gave him some picture magazines, but most of the time he lay motionless in his cubicle, his blue eyes looking expressionless at the blue sky. When I went through the wards, I could say, "Guten Morgen, Herr Sprengel," to him and he would smile.

One day when I went into this ward the "polio trio" were unusually complaining and caustic about "Schickelgruber." I found myself becoming angry, and with no attempt to control the emotion in my voice said to them, "Herr Sprengel is very sick—he is going to die. You are inhumane. He is not a Nazi. He did not want to go to war." From their expression it was evident that they were taken aback and at the time they made no further comment. However, I knew that I could use this tone of voice and be so direct because I had known the trio for so long and had developed a good relationship with them. Also, the captain was getting better and with improved health should be able to have some outgoing feelings for others. I discovered in subsequent visits that the captain had been able to use what I had said. I found that he was learning a little German from the nurse on the ward who spoke it. He was calling a few words of greeting over the partition to Herr Sprengel and attempting a simple conversation. He shared with him the fruit he secured from local Arab vendors. Shortly Herr Sprengel left on an evacuation train for "the rear" where there was a slight chance that he could get in on an exchange of prisoners and get back to Germany—if he lived that long. The whole ward called, "Auf Wiedersehen" as he was carried out on a stretcher.

About this time the captain's attitude toward his illness changed

also. He became cheerful and at each visit of the social worker he greeted her by boasting of some new achievement. He sat up, began to feed himself, to shave himself, then to write his own letters. He reported conversations with the nurses about the almost miraculous efficacy of special hospitals in the States, and said he knew a good part of his cure depended on his own efforts. His whole orientation toward his illness became positive. This change must be attributed in good measure to increased use of muscles as a result of ceaseless effort of the nursing staff. However, we must also consider change in psychic orientation when direction of energy reverses from infantile demanding of attention and self-pity to an active outgoing interest and effort on behalf of someone else. We know what a potent factor a healthy psychic orientation is in the recovery from this disease. Such opportunities for informal group therapy are frequent for the social worker who watches for them.

Letter Writing

The services of the social worker as I have described them this far hardly fall into the traditional concept of case work. Her skills and understanding are used largely in the quick identification of the need for service and a recognition of what is at stake, so that she is able to apportion energy and purpose and outline a program amid the clamor for services which would otherwise be overwhelming.

Time and time again, however, I found myself using professional tools not only in immediate recognition of need but also in treatment of the situation. One such situation arose out of the request for help in writing a letter. This is a very common request and frequently indicates a simple need. It was so in the case of a soldier who had lost his right arm. When he began to recover health and spirits he recalled his host of family and friends back home. One morning he brought to my tent a fat notebook full of addresses and asked me to help him go down the whole list.

Requests for help in letter writing frequently have many and varied implications and one always watches for the meaning behind the request. Case work skill such as was used in the following situation was called for more often than not. A soldier hesitatingly entered my tent and asked if I would write a letter for him to his sister back home. He said that he had tried to write it himself but his

hand shook too much and his mind was in such a state of confusion that he could not think of what he wanted to say. I asked him to sit down by my desk, got out pen and a V-mail blank, and asked for his sister's name and address, remarking at the same time it might help to see why he was having so much trouble in thinking of what he wanted to say to his sister. He never gave me his sister's name and address. Instead he began immediately to tell me of his recent battle experiences. He talked with great emotion and vivid detail, reliving all his experiences as he talked. He had seen his battalion commander killed a few feet away, his buddies killed one by one, and his whole battalion practically wiped out. He had taken part in an amphibious landing where his battalion had met a heavy counterattack of tanks and artillery that had overpowered them. The soldier spent an hour and a half telling me his story.

At the end of the tale, he seemed calmer and much relieved. He thanked me for listening to him and then remarked that he guessed he could write to his sister himself. I never knew whether he came actually for help because he found he could not write the letter, or whether what he told me was the letter, that is, that he was driven by inner necessity to have his sister share these experiences. In the latter case, of course, I became, for the time being, the sister. In this and innumerable other similar instances, the social worker uses her skills and understanding in listening. Skilled listening is one of the professional tools most frequently used in this setting.

A number of requests for help with letter writing arose in connection with telling the folks back home of the presence or extent of a permanent injury. On almost all occasions the difficulty lay in the man's facing the injury himself, or in his fear of the implications of it. With help around this point he could frame the words himself. Many psychiatric patients came in claiming inability to write because of trembling, haziness of thoughts, and so on. Before helping a psychiatric patient with letter writing, we were careful to consult his medical officer about the help that should be given. Sometimes we were advised that no help should be given, as in the case of a man whose blindness we were told was wholly psychogenic. Writing for him, it was feared, would only convince him all the more deeply that he was really blind. In other instances we tried to make our help lead to a greater degree of ego control. One man was certain that his hand shook too much for him to be able to write at all. I talked

to him about the impression of serious illness that would be given to his family if they saw his letters written by someone else. When he still felt that he could not address the letter legibly enough for the postmaster I agreed to type the heading of the V-Mail form while he wrote the body of the letter. After I helped with several letters he found that he could control his hand enough to write the whole letter himself, even the heading.

Troubles at Home

A number of complicated family problems were brought to the attention of the social workers. What could be done was almost always fragmentary, limited by the time the man was in the hospital and by the fact that rarely could we receive a letter in reply before the man departed. Referrals were usually made after the receipt of a disturbing letter from home. Here was a soldier, possibly ill of tuberculosis himself, who just received a letter from his wife who had known for several years that she had tuberculosis. The letter said that the Red Cross Chapter had just informed her that hospital facilities were not then available to her. The three children had been scattered among relatives whose ability to give adequate care to them the patient doubted. We could and did, of course, send a cable and follow-up letter back to the local chapter asking for details of the wife's condition and arrangements made for her care, and we asked for a study of the care being given the children. The patient would be gone before the reply came, but we hoped that the reply would reach him in a base hospital before he was placed on a ship to return to the States. In the meantime we could reassure him about the possibilities of care at home and the fact that something was being done.

Occasionally much more help could be given the man in discussing his problem. A 30-year-old soldier, a cook, was sent in from a local battalion. He had run amuck, threatening everyone around him with a kitchen knife, and then had dropped into a stupor. It was found he had received news from his wife that she was taking steps to divorce him. He came in to us with the request that we ask the Red Cross Chapter back home to interview his wife and persuade her not to divorce him, and that a check be made with his sister to see whether she was still handling the wife's finances. She had promised

to do so because he could not trust his wife to manage her own money. Before talking with him any further, we consulted the psychiatrist on the case. The psychiatrist felt that the man's hysterical condition was so involved with the relationship with his wife that it would be impossible to treat him in North Africa sufficiently for him to return to duty. He would have to return and straighten out his relationship with his wife first. In the meantime, while he was waiting in our hospital for an evacuation train, the psychiatrist would be glad to have us discuss with the man the resources for help back home.

The soldier came in almost daily in the two-week period in which he remained in the hospital. He gave us a detailed story of a long period of marital difficulties during the nine years of his marriage. He and his wife were evidently very immature people, dependent on each other, interacting with aggressions and hostilities. Apparently the man was much the stronger personality. He had been able to insist that his wife remain away from her own family, which was domineering and constantly used differences in racial customs to try to turn the wife against him. According to his story, the wife was quite inadequate to manage practical affairs, and when he left for overseas he had tried to place her under the control of his own family, particularly his sister. It was evident from her letters that the young wife resented this control and was probably hitting back at the husband by threatening divorce. The stories of her running around with other men might or might not be true.

Our first efforts were to try to help this immature young man get control of his emotions, in which he was practically allowing himself to drown. First, he was able to see that the story about the divorce action was only a threat, since it is very difficult under present laws to divorce a soldier overseas, and that probably the wife knew this. Details of their long story of difficulties were gone over with him and it was found that he was capable of some insight. He could see how he had reacted in the past to her shortcomings, and could understand how lost she would be without the help he had formerly given her. He was tremendously relieved to know that there were agencies that were in a neutral position, unlike the battling families, who could give his wife the help she needed. During this period he grew calmer and better oriented. He agreed to a letter to the local Red Cross Chapter outlining the situation and requesting help for his wife. This was sent at the time he left the hospital. He was given a letter

of introduction to the Red Cross to be presented at any hospital to which he might be sent in the States, simply stating that he had discussed family problems with us, that he would be in need of further help, and that a letter had been sent to the local chapter in his wife's community. The soldier was sent on to a base hospital in the rear where he was to await a ship to the United States. We had no way of knowing, of course, whether, with further treatment and help at this hospital, the decision of our hospital would be reversed and he would be sent back to duty, or whether he did return to the States.

Re-establishing Home Ties

One situation gave me a little more professional satisfaction than usual inasmuch as the soldier remained long enough to see a treatment process carried through to completion. Such situations were very rare and hence clearly remembered.

One morning a timid, very serious little man, apparently in his middle thirties, advanced into my tent, and apologetically asked for a comb. Now there was no reality reason for embarrassment at this request. The local post exchange had no combs and we were distributing them to everyone who asked for one. Something in the man's demeanor, the way in which he hesitated about leaving, led me to inquire whether there was anything else I could do for him. Yes, there was. He had not heard for many months from a cousin with whom he had been very close at home but he had facts that led him to believe that this cousin was stationed in a city only a few hundred miles distant from the hospital. If we let this cousin know where he was, he might be able to visit him. There was something so urgent in this man's voice that I agreed to use the very crowded army wires and put through a long-distance telephone call to the Red Cross Field Office in the distant city. But before doing this I consulted the man's medical officer. There was some question about physical ailments but the basic diagnosis was anxiety neurosis. He had been in combat, subject to air strafing for some weeks, and had been sent back at the command of the battalion medical officer. The chief psychiatric symptom was a marked startle reaction. When planes flew over the hospital, even though he knew they were friendly planes, he would dive under his bed, or sometimes completely collapse. It had not been decided at this point whether the man would be able

to return to duty or would have to be returned to the Zone of the Interior (the United States). When the call to the Red Cross Field Office was put through, something of the man's emotional condition was given and the urgency of his wishes stressed.

The next day he returned, a little less timid, and asked if he might sit down and talk with me about something that he wanted to ask of me most of all. He hadn't the courage the day before. It was about his mother. He had not heard from her for several months. She had been in ill health for many years—was "nervous." He was an only son, unmarried, and there was evidently a close attachment. When he went overseas she suffered a collapse. Could the Red Cross find out how she was without letting her know that he was in a hospital? It was agreed that a letter would be sent, since this seemed preferable to a cable under the circumstances. The patient was then led to tell something of his combat experiences, which he did in a hesitating way. He told of his loneliness and how difficult it was for him to make friends and exchange confidences with his hospital mates. He asked if the social worker had time to talk to him now and then. He told of his battle dreams and feelings of evaporating into nothing when the planes came over. He had always been a nervous person but had never felt like this until his combat experiences. He doubted that he could ever go back into combat again, but he did hope to get better so that he could be useful in the war effort in a rear-line unit.

The following day he came in beaming. His cousin had telephoned the hospital from the Red Cross Field Office and had talked with him. He did not know when anything had made him feel so good. The cousin did not think that he could visit but he could telephone occasionally. The patient came in about every other day. He would wait around the tent and watch for a time when I did not appear to be busy. We talked of both personal and impersonal things, his family and life at home, literature and politics, in which he had considerable interest. No attempt was made to interpret to him the nature or effect of his close tie to his mother because he seemed so easily threatened, and he was not under the care of a psychiatrist who could be consulted. It was hoped that with the rest and hospital routine, and a friendly relationship that would carry him along, he would be restored to the level at which he had been before combat.

Because he was improving he was kept in the hospital for some weeks, long enough for a reply to our letter to come back. The mother was in her usual health, good except for the nervousness. She had already been informed by the War Department of her son's hospitalization and was tremendously relieved to know that it was merely for " nervousness " and a rest. The patient was most helped by the information that his mother knew he was in a hospital. Now he could write her, which he had been unable to do before, because this kind of man is unable to lie easily. It was found by the medical staff that there was no physical ailment except that taken care of by rest and he was discharged to B duty, that is, duty in a non-combat unit. His extreme reactions to noise and acute anxiety had disappeared, although, of course, he was still an unstable personality. Before he left, he came in to thank me, saying that what I had done had helped him more than anything else. In discussing these remarks later with the psychiatrist I was told by him that frequently the factor of most use in helping the psychiatric casualty back to recovery was the receipt of news from home and the re-establishing of the supportive family relationships.

II.

IN A NEUROPSYCHIATRIC HOSPITAL

MY EXPERIENCE in the second hospital in North Africa was very different from the first, for my assignment as a psychiatric social worker to a neuropsychiatric hospital presented singular opportunities and situations. The function of the two hospitals differed: the second hospital admitted only neuropsychiatric patients. The setting differed: this hospital was in a base area, many hundred miles to the rear of the zone of combat. The uses the staff wished to make of the social worker differed. Most of the psychiatrists on the staff were accustomed, in civilian practice, to the help of trained psychiatric social workers. The Red Cross staff was viewed as an integral part of the treatment process, the head of the Red Cross Unit was included in hospital staff conferences, and the details of the Red Cross program were worked out in conference with the Chief of Psychiatric Service. The only limit to the use of one's professional skills in this setting was that of time and energy. But there were similarities too. Here, as in the other hospital, were the rows of olive-drab tents, the same mud, and the familiar struggle with lack of equipment and supplies.

This experience was unfortunately brief, only three months long, and at the end of this time factors having to do neither with my wishes nor with the hospital situation brought about my return to the United States. These three months were in November, December, and January, 1943–1944. This period just covered the rainy season and the weather played a role in all our activities. When people are living in tents in times of torrential rains and bitter cold, with army regulations permitting stoves only in hospital wards and even then the sharply rationed coal running out, with every sliver of wood in an almost treeless country more highly prized than diamonds, the elements form a constant backdrop, conditioning one's activities. The

effort just to get army permission to have stoves placed in the Red Cross tents, then the organization of patients into fire brigades, and the constant watch over the fuel supply, all made inroads on time and energy that might have been put into work with patients. There were mornings when I arrived at the Red Cross tent to learn that the reliable patient who had charge of building the morning fire had suddenly been shipped out and the coal supply was gone. Shivering under sweaters, wool cap, mittens, and overshoes, I discovered that the night's heavy rains had leaked through the tent, that supplies, library, and equipment were soaked. Fortunately, these difficulties never produced more than a fleeting moment of discouragement, and I think this was true of the rest of the staff as well as myself. Facing and overcoming such obstacles were a part of daily life and we became accustomed to the effort they caused just as one becomes accustomed to the effort of breathing.

Population

The patient population was composed of two groups. One group was sent to the hospital from the military units in the area. These were the men who failed to adjust to military life or who might have developed acute difficulties of adjustment under any circumstances. There were men who were alcoholic, the psychopathic, those unable to adjust to military discipline, those developing acute anxieties after coming overseas because of the separation from home, and a large group of psychoneurotics with somatic complaints who managed to get along in military life during the training period at home but who broke down under the increased hardships and strains of life overseas. In addition we had a group of true battle casualties: the soldiers who broke down in combat, merchant marine personnel who had been torpedoed on one or more occasions, officers who had broken down under the pressure of long hours and heavy responsibility. I got the general impression from my acquaintance with these battle casualties that for the most part they had been as well adjusted and emotionally healthy in civilian life as the average person. The one set of figures I have seen from military studies bears out this impression. It was the circumstance rather than the man which caused the breakdown.

With the battle casualty the symptoms were apt to be most severe, but with prompt and efficient treatment the recovery was often most rapid and remarkable. Battle casualties were sent to us either direct from Italy or from another base hospital area nearer the theater of combat. In either case the patients had already been through two or three hospitals before reaching us and the secondary symptoms had often set in and become fixed. For this reason a large proportion of our patients had to be returned to the States. The rest were returned to either full duty or limited service.[1] Because of the limited facilities at this time for returning hospital patients to the States, patients were apt to remain in our hospital for a lengthy period, frequently several months, waiting for a hospital ship. However, whatever the disposition of the patient and his length of stay, it was the policy of the psychiatric staff to give active treatment as long as he remained and, of course, the Red Cross staff shared the responsibility for that treatment.

Activity as Treatment

Except for a few psychotics in the closed ward and a few in the one ward reserved for the physically ill, the entire patient population was ambulatory and able to engage in activities. It has been generally recognized, both in the last war and in the present one, that in battle neurosis the breakdown occurs in the ego structure. Therefore it was of the utmost importance during the period of hospitalization to encourage the functioning of the ego in every possible way. All the hospital services strove to find a wide variety of activities in which the patient could have the experience of " I can do that " and in which the ego again learned to dare to compete with others. Activity also helped to dispel the patient's idea that he was sick and the consequent feeling of helplessness and dependency. With these principles in mind, the patients were taken out of the regulation hospital pajamas and put into work fatigue uniforms. Also, it was a policy in all departments, including Red Cross, whenever practical, to give the immediate responsibility for projects to the patients themselves after a project was set up. This giving of responsibility was

[1] Because of security restrictions, I am not able to give any figures or percentages or to quote military sources of information.

an important therapeutic tool used by all of us, as will be frequently illustrated in this section of this paper.

Although I have included considerable detail about the recreation program in this hospital, this will not be fully described, since it is my purpose to show the function of a social worker in such a setting. However, a certain amount of detail about the recreation program seems to be necessary for two reasons. The first is that, in a hospital set up to treat only neuropsychiatric patients, it is neither possible nor profitable to separate the two programs of recreation and social work as distinctly as in the usual hospital. The program had to be worked out to fill the needs of the emotionally ill with their specific disabilities in mind. Hence the understanding of a psychiatric social worker enabled her to be of special help to the recreation worker while the recreation program was being formulated, and the program was peculiarly the result of joint thinking and planning. Also, the insight of the social worker enabled her to see implications in the suggestions and wishes expressed by the patients as she talked to them, so that she could see and seize opportunities to develop the program according to their needs.

Second, the recreation program provided situations in which the social worker could help individual patients come to grips with their individual problems. The social worker was called upon to deal with the personal interrelationships and emotional reactions involved in the activity programs. Our program provided illustrations of the partnership that can exist between social workers and recreation worker.

It will help to give perspective to the work of the Red Cross staff in the treatment program of the hospital if some of the responsibilities and activities of the other hospital services are outlined. Of course, there could be no watertight divisions between the function of the psychiatric staff, the nursing staff, the ward men of the detachment, Special Services, the chaplain, and the Red Cross staff. Our activities frequently overlapped, and often we all shared some activities together. Certain broad divisions of responsibilities, however, were defined.

Directly under the supervision of the psychiatric staff there was a program of rehabilitation that was obligatory for all patients except those especially excused. The morning was set aside for physical

activities. The patients were given a wide variety of duties in the maintenance of the hospital according to their experience and aptitudes—the usual K.P. and latrine duties, typing, sorting mail, supply, laboratory, and so on. A sergeant-patient made up the duty roster. The Red Cross staff called upon this sergeant to supply men for policing, fire details, and other help. Under this program also was a wide variety of athletics—football, volley-ball, basket ball, tennis, and horse shoes. The patients went to work eagerly in the construction of the playing fields and equipment. It was a red-letter day when the patients' football team played a game with the detachment men and led the game at the end of the first half. It was a part of the nurses' duties to participate in these athletics and to encourage the men to go out for them. The psychiatric staff believed it to be therapeutic for as large a group of women as possible to take part in activities.

To the Red Cross the hospital assigned the task of providing activities for the patients every afternoon and evening except for the two evenings a week reserved for the chaplain. We were asked to provide a program with enough variety to interest all the patients able to take part. This meant that a number of programs frequently went on simultaneously.

For this large assignment there were three of us, a recreation worker, the staff secretary, and myself, the administrative head of the Red Cross Unit. The recreation program was of sufficient size and importance to engage all three of us. Our secretary spent very little time in purely secretarial duties. She served as hostess to the day-room and was responsible for running the library, giving out Red Cross supplies, and supervising the newspaper. Our recreation worker was, of course, responsible for the overall co-ordination of the program. Her special responsibilities included a craft shop, the program of movies, parties, or other entertainments every evening, and the supervision of patient-produced shows and dramatics. I undertook to assist with special projects such as the band, a garden project, and work projects such as the building of the stage. It was my special province, of course, to co-ordinate the case work needed by individuals with the recreation program. We were advised to limit the purely passive kind of entertainment such as movies. We stressed group and social experiences and work projects in order

to help the patients recover from their irritability, feelings of hostility, and reactions against authority.

This tremendous recreation program for which the Red Cross Unit was held responsible would not have been possible except for the help so freely given by every service in the hospital. For example, a medical detachment man with a special musical background rehearsed the patient-band.

A group of nurses with special abilities, who were designated by the hospital as nurses in recreation, were assigned to assist the Red Cross and became practically a part of our staff. They attended a weekly meeting presided over by our recreation worker when the details of the recreation program for the coming week were worked out. The nurses who had special abilities in dramatics assisted in rehearsing and putting on plays and skits written by the patients. They played cards and other games with the patients in the day-room. They were also of great help in reporting back to Red Cross at these weekly meetings the needs and recreational interests of individual patients so that we could provide for them. One nurse instituted the practice of asking each patient, as she prepared to put the thermometer in his mouth for the morning temperature, what he was interested in doing that day. At the end of her morning rounds, she had one column of temperatures and another column of interests and talents. The nurses were of great help to us in finding reporters for the paper, masters of ceremonies for shows, organizers of ping-pong tournaments, keepers of the tool room, and so forth.

A Building Program

A good share of time was taken up in directing our "labor," that is, the construction of the Red Cross physical setup, and this in turn provided a part of the activity program. When we arrived at the hospital, the Red Cross plant and equipment consisted of two tent platforms—nothing more. And there were already hundreds of patients milling about and making requests. The hospital shortly put up two ward tents on the platforms, but the tents were still empty. We needed furniture, partitions, supply closets, and book-shelves before we could start to work. My second day at the hospital, a psychiatrist approached me for help with one of his patients, a skilled carpenter, who was badly in need of something to do. Our

need and the patient's coincided. This was the beginning of the work projects. Shortly after that we had groups of patients everywhere—sawing, hammering, painting, cataloging the library, and making recreational equipment for themselves. The noise of hammering and sawing could be heard over the whole hospital. One patient's whole time was occupied making signs, which he did beautifully, advertising our recreational programs.

None of these projects was "made work"; they all had to be done. These necessary labors reproduced a miniature reality setup in which the patients had to work with one another and the hospital personnel, to adjust to limitations, and to work under authority.

I am describing first the kinds of situations in the recreation program in which the social worker took part and where she could use her skills and insights. Later I shall give illustrations of what a social worker found she could do in the purely case work program. I divided my time about equally between my administrative duties, the case work program, and the recreation program.

Shortly after the hospital opened the inclement weather made it impossible to show movies out of doors. A large circus tent was secured by the hospital. The hospital administration found a patient who was an engineer and put him in charge of erecting the tent. Patients built a large and serviceable stage. We put this task under the supervision of a patient who had been a scenery designer before entering the army. The man had genius in his craft and, what was more important, in finding materials. Pulleys, sizing, dozens of small items needed for the stage curtains and scenery were, of course, unprocurable through the army. He became acquainted with the local French tradespeople and he put his fingers on any needed item in a manner that seemed sheer magic.

This man was a psychopath and alcoholic, extremely irritable and difficult to work with. I spent many hours soothing the feelings of the men who worked with him, and in persuading him of the necessity of coming back sober when he had to make trips to town. But our handsome curtain got designed, our artist blocking out the patterns that other patients could paint in, drapes about the stage got put up, a battery of stage lights was installed by an electrician-patient, and we had reason to believe that we possessed the handsomest stage in North Africa. When all was completed, a famous Polish pianist visited our hospital and gave a memorable concert. A good part of

the hospital had taken part in the completion of our theater and could take pride as well as pleasure in that performance. It might be asked what we got our patients to do when the last piece of furniture was painted and the last tack put in the stage scenery. The course of the war seems to be taking care of that problem. Shortly after I left, the hospital was pulled down and moved to another zone of operations where the process had to be started all over again.

Patients' Projects

This stage provided one of our most useful recreation opportunities. While Special Services sent us many enjoyable shows from their schedule of regular road companies, actually I am sure the patients enjoyed most their own shows. Each week we had an amateur night. There were always professional pianists and show people among us, and a succession of excellent masters of ceremonies organized and put on these shows. Our patient-band took part in them.

I shall never forget a young violinist, formerly a member of one of our finest philharmonic orchestras, who was brought into the hospital in a stuporous state, with a diagnosis of dementia praecox. As soon as he became aware of his surroundings he began, in his own closed ward, to play his violin, which he had always managed to keep with him. His psychiatrist then asked my help in providing him with wider opportunities. I met him and talked with him about how much the other wards would enjoy his playing. He was most hesitant at first but finally agreed. He was then introduced to the recreation worker. She suggested playing in other wards and helped him over the hurdle of his dislike of meeting new people by calling for him every few days and accompanying him from ward to ward. He enjoyed the reaction of the patients to his playing and gained in alertness and self-assurance. Shortly afterward his psychiatrist reported to me our violinist was ready to appear before an audience in the big circus tent. The recreation worker arranged to have him put on a program and accompanied him to the wings of the stage. He brought the house down with cheers and came off the stage beaming. After this first experience he made his own arrangements about subsequent performances with the patient who acted as master of ceremonies, and because of his popularity was called upon for

every show. Other local hospitals heard of him and invited him to play for their shows. When he left our hospital, he was as well as he had ever been and it seemed likely he would be able to rejoin his orchestra after his discharge from the army. His psychiatrist told me he had literally played himself back to health.

There was always a great deal of informal chatting with the men who gathered in the day-room. On one occasion a patient remarked with a good deal of hostility in his voice that he would love to write a take-off skit on the hospital Disposition Board. This was the board that decided whether the patient should go back to combat duty, be reclassified, or be returned to the Zone of the Interior. On the board sat the Chiefs of Staff, and strict military courtesy was required. Patients shined their shoes and had their hair cut beforehand, and an appearance before it had all the emotional elements of appearing before the Judgment Seat. The very calmest of the patients went into a cold sweat for twenty-four hours beforehand. I used to watch the patients lined up on a bench awaiting their turn, chewing their fingernails and staring into space. Such a situation, of course, had a tremendous amount of meaning for patients and usually brought out a full display of their neurotic difficulties. It was certainly charged with hostility. So I seized on the patient's suggestion about the skit. When I took his idea seriously, he wanted to back down, but with some assistance from me and my assurance of securing permission from the chief psychiatrist, he elaborated on his idea. Various other patients offered suggestions and soon a committee was formed. The recreation worker took the project over at this point, since the writing and production of skits and shows by patients was her responsibility. We talked it over and I outlined the therapeutic values of the idea and suggested that there be no censorship except the final one before production. The skit was eventually elaborated into a whole show.

After writing up a board the patients turned to their own foibles and poked fun in a very healthy way at their own neurotic and irresponsible behavior about the hospital. The show "So You Are Boarded" turned out to be a huge success and was put on also at various other nearby hospitals and at the Red Cross Club in town. The psychiatric staff found that there was real therapeutic value in the patients' being able in this way freely to express their hostility to the medical staff and hence to all military authority and not meet retaliation or punishment for this expression.

There were many instances in which a social worker, during informal mingling with the patients, picked up and encouraged projects of therapeutic value, and then turned them over to other members of the staff. A patient happened to mention his interest in plane identification and the fact that he had previously conducted classes in it. He was interested in organizing a class here and had talked to several other patients, but had been stopped by lack of equipment. Projects of military nature were particularly valued by the psychiatric staff in order to remind the patients that they were still soldiers and to encourage satisfaction in that fact. Hence this patient was referred to the recreation worker for help in his wishes and they were worked out very satisfactorily.

The newspaper produced by patients was placed under the guidance of one of the staff workers, but occasionally I asked permission to sit in on editorial conferences. Once, during a discussion, the subject of the medical staff's use of sodium amytal in treatment came up; the almost universal fear the patients had of this treatment and many misconceptions about it were expressed. A drug that sets aside the patient's will and uncovers forgotten memories causes something of the terror of primitive magic to those not understanding or trusting the intent of the user. Its use among the patients around him also causes anxiety in the neurotic that his unconscious "goldbricking" will be discovered. I asked the editorial board if they thought the use of sodium amytal might not make a good news story, and arranged for a reporter to interview the chief psychiatrist for his facts. The story was written up in a most colloquial and amusing way, but the facts were all straight, and the patients could better accept the purpose of the drug told in this form than in any other. The story helped toward improved confidence in the medical staff and improved relationships between patient and doctor.

This newspaper had many values for those working on it. I particularly remember one editor, an alcoholic, who was a newspaper reporter in civilian life and a graduate of one of our best universities. He secured a tremendous amount of prestige from interviewing the hospital officials, particularly the commanding officer, and attending regional conferences of editors of mimeograph papers. The newspaper kept him sober at least most of the time while waiting for his boat back to the Zone of Interior. If he had had to remain idle during these months I am sure he would have completely deteriorated.

Moreover, he made an excellent editor. Because of his departure and several other problems (difficulties occurring all at once over use of a mimeograph machine, exhaustion of stencil supplies, and the sudden recall of our typewriter, borrowed from the Signal Corps) the newspaper nearly collapsed, but, gritting our teeth, we made strenuous efforts and resolved " It shall not die." Our secretary and I sweated over each obstacle and eventually the two of us got it going again. As in many other instances, it seemed that the chief qualification needed for Red Cross workers overseas was a resolution of steel. The difficulties were so many that at many points the whole program seemed about to collapse. There were times when I felt like Atlas carrying the whole of it on my shoulders.

Irritability—a Form of Battle Neurosis

One more instance illustrates the kind of situation in which a social worker used her skills in helping patients to learn to live in the reality situations provided by our projects. Shortly after the hospital opened, Whitey, so nicknamed because of his blond hair, was admitted. He remained a patient as long as I was there. Whitey was a corporal who had gone through the whole African campaign with an excellent military record but, after a long period of exposure to enemy shelling in the final Tunisian round-up, developed an irritability so severe that he was hospitalized. This irritability is a common form of battle neurosis. He had been in hospitals several times, discharged each time to replacement pools, but always when he was put under any pressure or found himself in a disagreeable situation, he would " blow his top," to use a good G. I. phrase.

Whitey was about 22 or 23, an extremely intelligent and competent person with such a flair for things mechanical and electrical that he made a very valuable soldier. For this reason the hospital decided to keep him on as a patient to see what help could be given him over a period of time. This course seemed particularly wise in view of his history as a well-adjusted civilian with an excellent work history and stable family relationships. Moreover, Whitey was popular among his fellow patients. He was one of the first to volunteer to build the stage for the circus tent and worked on it early and late. He put in the flood lights. Our scenery designer superintending the job was temperamental and quickly turned to another interest when

the stage was about done, leaving the management of it to Whitey. At this time we acquired a complete public address system, with loud speakers placed about the hospital grounds, and controls behind the stage. Whitey was the only person in the hospital who knew how to install and operate it (our engineer-patient had departed), and immediately appointed himself to take over the job. Whitey became the manager of the circus tent, scheduling the use of the stage for rehearsals and programs, selecting and scheduling radio programs to be broadcast over the public address system. He also became business manager for the patients' radio station "At Ease" which broadcast skits and its own musical talent an hour every day. Whitey became a most indispensable member of the Red Cross staff.

His psychiatrist, soon after Whitey's arrival, had told me about Whitey's abilities and his difficulties and had suggested that I watch and help when I could. I made a point of stopping in at the circus tent frequently, chatting about progress and plans, and becoming acquainted with him. There was no doubt but that Whitey was making progress in a job that gave him many satisfactions. Inevitably there was difficulty with our scenery designer, but Whitey grumbled away his irritation to me, recognizing that this man was "temperamental," and no serious trouble occurred. Also, he learned to accept complaints about the radio from patients and hospital personnel. The patients would want jazz at a certain hour, then the dental office would telephone down to complain that their symphony hour had been cut off. At another point, when Whitey recognized with me that he was becoming constantly irritable, it was decided he had been working too hard—which indeed he had—and it was arranged that he take time off.

At this point, a new training officer in charge of rehabilitation was appointed to the hospital and was given administrative responsibility for the many varied uses to which the hospital put the circus tent. After a conference with Red Cross it was decided that he would have a conference with all the leaders of patient-projects who used the tent. Knowing how sensitive Whitey was about his prerogatives in the circus tent, and how much emotion he had invested in his duties there, I was careful to inform him of the changes that were to be made, and to assure him that he was to remain at his post. This change took place smoothly.

As is the way in the army, however, we shortly lost this special training officer, and his duties in regard to the circus tent were taken over by one of the executive officers of the hospital. The change was made suddenly and I had no opportunity to talk it over with Whitey. The Special Service officer, who had a naturally brusque manner, walked into the tent and simply announced to Whitey that he now had charge of the tent. Whitey said nothing to the officer—he had learned that much self-control—but he walked off the stage and retired to his ward tent. That day there was no music floating over the hospital area, no news, and no popular skits. The hospital was a much duller place. Everyone asked, "Where is Whitey?" But Whitey continued to sulk in his tent. To his psychiatrist, who looked into the trouble, Whitey vehemently declared that he was told that no patients were wanted around the stage, that he was ordered out. This, of course, was not true, but it was a revealing projection of his own fears, and showed the nature of his emotional difficulties. The immediate problem was worked out by the psychiatrist. Whitey was assured that he was wanted back and returned to his duties. However, his anger and irritability toward the new officer remained.

The same day that he returned to duty he came in to me to explode over a request that had been made of him. This request was that the schedule for use of the tent be kept in the office of the Special Service officer, instead of in the Red Cross Office as before, and that Whitey go there to write in schedules as they were given to him. He did not want to have anything to do with this officer, nor to go near his office. He was afraid of what he might do or say. I let Whitey explode to me, then later asked the advice of the psychiatrist about dealing any further with the problem. I was told that since Whitey had come to me about his feelings, it appeared to be his choice that I help him.

I returned to talk to Whitey in the circus tent. From the immediate problem of his refusal to follow orders about the stage schedule, it became possible to discuss with him his whole problem of irritability and reaction to authority. He had made considerable progress in the hospital, as was shown in his ability to refrain from exploding at the officer and his consent to return to his duties. This was the first time, however, that I had dealt directly with the reason for his being in a hospital, and I found that Whitey was now able to discuss this with me. By this time he had had enough satisfactory experi-

ence in the hospital and had built up a strong enough relationship with me to face seriously what the consequence of his behavior would be, not only in the army, but after his discharge. In this interview he decided that he would do what was requested of him about the schedule.

In a third interview I took up with Whitey his statement that the Special Service officer had told him that he was not wanted around any more. With considerable irritation he admitted that this was not exactly what was said to him but he thought that this was what was intended. From this point he was helped to recognize that this was the way he thought everyone in authority had felt about him lately. He then recounted to me with considerable emotion the last weeks of his battle experiences, which had been harrowing ones. I did not see Whitey again because I left the hospital. I learned from reports, however, that he had been transferred from patient status to that of a regular member of the detachment, that he was working directly under the Special Service officer who had first aroused his anger, and that he was getting along all right.

A Severe Traumatic Neurosis

Our activity program, because of its variety, could be adapted to a wide range of patient-capacities. In striking difference to the competent Whitey was a soldier who, when admitted, had all the symptoms of catatonic dementia praecox. He did not speak except to repeat verbatim what was spoken to him. He suffered loss of memory, and his limbs had the wax-like stiffness of the catatonic. His hospital history indicated that when first brought from the battlefield his symptoms were those of acute anxiety, and only after hospitalization did this anxiety convert itself into his present set of symptoms.

Under psychiatric treatment, with the use of both sodium amytal and psychotherapy, he began to talk a little, to use his limbs a little better, and to recover some of his memory. It became evident that he was not a dementia praecox case, but was suffering from a traumatic battle neurosis. At this point the psychiatrist requested the social worker to supplement the psychiatric treatment. The patient needed help in establishing relationships both with his family back home and with someone in the hospital. He needed some occu-

pation. I found that he had just remembered his wife's name and address, and that he had not heard from her nor written her for many months. The Red Cross was able to send a cable, with some explanation of why the soldier had not written, and asking about the welfare of the family. Then I wrote letters for the man to his wife as he dictated, since he was not yet able to manage to use his hands well enough to write himself. All this time I was getting acquainted with the soldier, as far as his condition permitted it. Realizing that the usual interviewing situation would be a strain because of his limited ideational expression, I used our ever-present painting jobs to help along. I would call for him at his hut and talk with him on our way to the Red Cross workshop. He seemed delighted to paint for us and was fairly competent on simple surfaces like tables. For a long time his work was automatic and he would not stop until I returned to tell him to do so, and led him back to his ward. The patient continued, however, to make progress while I was at this hospital.

Case Work in the Traditional Sense

As far as what might be called case work in the traditional sense was concerned, my short experience in this hospital can only outline and suggest possibilities. There is little to recount of real achievement in this type of work. The psychiatric staff urged me to accept patients for supplemental individual therapy and to conduct group therapy, but limitations of time allowed only a few cases of the former and no attempt at the latter. In addition to the duties I have outlined, there was a considerable volume of communications with relatives, including inquiries from the folks at home puzzled by the patients' letters about the nature and extent of their illnesses. This volume of inquiries of course reflects the lack of general public understanding about the meaning of psychoneurotic difficulties in the army. Our Red Cross Unit had the usual staff complement for a hospital of this size, but because of the nature of our duties we had additional needs. At this time, because of the shortage of trained social workers in overseas duty, it was not possible to secure additional staff. I might add that, at the time of writing, the hospital has secured the two social workers so badly needed.

In a meeting with the psychiatric staff there was a discussion of how I could best help them in case work with individual soldiers. Of course, in this setting, the psychiatric social worker was unable to function in her traditional role of working with family and environment. It was agreed that there were no precedents to follow, that referrals would have to be tested out, case by case. It seemed at that point that the social worker might be of most help in two kinds of problems. One might be in situations in which the neurosis manifested in the hospital had been superimposed on conflicts around the situation at home. Here, because of her knowledge of resources at home, the social worker might be of special help. The second kind of situation might be that in which a patient, while resisting help from a man, could form a relationship with a woman and might be helped by a supportive relationship with the social worker in the hospital.

I am giving a summary of each of these types of situations. The examples are chosen, not to illustrate exceptional case work, but rather to show the typical kind of situation in which a case worker can be of service in an overseas hospital. An office had been set aside for me in one of the clinic buildings so that I was always able to conduct interviews in privacy.

Headaches and a Marital Conflict

When referred by a psychiatrist the hospital record of Pvt. John Walden [2] gave the following information. He was 26, married seven years ago, and divorced two years ago, and had a 4-year-old son. He was born and raised in Ohio and attended the University of Illinois for two and a half years, and then the State Teachers College for a year. He left school only a few months before graduation because of violent headaches. He had had a serious automobile accident in 1937, had suffered a skull fracture, broken leg and clavicle, and had had headaches ever since. These headaches had interfered with his sleep and made him decline in his studies so that he had been forced to leave school. The patient enlisted in 1942 and was shortly afterwards hospitalized in a station hospital. He has had physical complaints ever since coming into the army. He was given a B classification for non-combat duty, and since coming overseas

[2] All personal and place names changed to avoid identification.

has worked in the army postal service, but was unable to carry on here. He made numerous reports at sick call but no physical basis could ever be found for his complaints. A series of X-rays all showed a perfect healing of the skull fracture.

When the psychiatrist referred the patient, he hoped the social worker might find some way of helping him in the problem of his relationship to his divorced wife. Pvt. Walden had indicated that he feared that he would lose her if he remained overseas and he wished to return home to arrange a reconciliation. It was thought that this problem had a direct bearing on his headaches, and it was hoped he could be given enough help so that he could remain on limited duty overseas. Patient was remaining in bed in his ward except for the time he spent on K.P. duty. The psychiatrist agreed to prepare the patient for my talking with him. The patient had been very surly and unwilling to talk in his interviews with the psychiatrist, and it was decided that it would be wisest for the social worker to make the actual arrangements directly with the patient for the time and place of the interview.

When first seen Pvt. Walden was found in bed; he propped himself up for the interview. He was a tall, slender young man with an intelligent, expressive face. He seemed friendly to me from the first and elaborated easily in response to questions. He replied to my statement that the psychiatrist had asked me to talk to him by stating that his only trouble was his headaches. He was insistent that they were caused by the auto accident. They have never ceased since then, but they have been much worse the last four months. This was because of all the pressures in the army, because he was not able to relax, to be quiet, to be by himself. He was sure that no army doctor could cure him. He had had to give up his completion of his schooling because of the headaches. He held on as long as he could but finally he had to take a rest and went home. Then he taught school for a while, but he didn't like it and gave this up again to go home. The trouble with the army was that he couldn't give up his job whenever he felt ill.

When asked about his wife, he told me that he was married when he was nineteen and his wife sixteen. His father opposed the marriage because they were too young. He knows now that his father was right. They were just kids. They were very happy for the first

three years, and then minor frictions piled up—the interference of his mother-in-law, for example—and the two of them agreed to a divorce. Patient then showed me a picture of his son and glowed with pride. His wife was writing to him every couple of months. She didn't say so directly, but he read between the lines that she would like him back. He knew that their marriage would go better this time. He had learned a great deal in the army about how to get along with people. He realized now that his marital problems were as much his fault as his wife's. After all, their troubles were only small ones that could have been settled easily had he and his wife both been more grown up. Patient talked spontaneously and thoughtfully about his own family situation.

In his own family he was the youngest child and only son. His three sisters were grown up and married when he was a child. He was given everything he wanted by his parents—much more than was good for any child. He never had any responsibilities and never had to share anything.

Pvt. Walden wanted to go back to his wife. He had always had a private income, so he could start a business of his own and arrange to be away whenever he got one of his headaches. When asked why he thought he would be better off at home than in the army, patient replied that when home he had headaches only occasionally, once a week or once a month. He could endure these if he had something to work for. If he were happy he wouldn't have so many headaches. He concluded that being happy relieved tensions and nervousness so that headaches went away. He would "give a million to be able to stay and fight" but this was said without conviction.

Patient agreed that it was important for his future happiness to consider a little what were some of the causes of the tensions and nervousness that produced his headaches. He thanked me most heartily for calling to see him. Arrangements were made for an appointment at my office in three days.

In a conference with the psychiatrist it was agreed that Pvt. Walden was an infantile young man, and he now had so little drive to remain in the army that it was unlikely that he would allow himself to be cured of his headaches while overseas. On the other hand, he seemed intelligent, capable of a good deal of insight, with a strong drive to work out his relationship to his ex-wife. While it seemed

certain now that he would have to be returned to the States, it seemed possible here to help him gain some insight so that he would be a better citizen when discharged. It would be in line with the policy of the Surgeon General's office to go on with interviews as long as patient continued to make progress.

There were three office interviews with Pvt. Walden. Always at the beginning of the interview he stressed the present severity of his headaches, how they kept him awake all night so that he was tired out and had to stay in bed in the daytime. His headaches were made much worse by his K.P. duties but he didn't ask to be excused because this was his army duty. Further time was spent in discussing his family relationships. He was able to see that his upbringing made it difficult for him to face unpleasant and onerous tasks in the army, that he had become accustomed to giving up and going home when things got difficult in civilian life, that his inability to do so now was his problem in the army.

Most of the time was taken up with tracing his difficulties with his wife. This seemed to be patient's absorbing interest when he was not immersed in his symptoms. At first he stressed the part played by the critical attitude of his wife's relatives. Later he recalled that the rift really occurred first when he took his wife home to his own family to live. He puzzled over the strained attitude and dislike of his mother toward his wife, and then began to see that his mother could not forgive the wife for taking him away from her. He could remember how upset he was himself in this situation. He began talking of plans of returning to his wife. He expressed real dread that some other man would get her. He felt that life would not be worth while in this event. At the end of the third interview he questioned if it would be necessary for me to see him again. He spoke of all the help I had given him in understanding the cause of his trouble with his wife. Then he ended up by more vehemently than ever insisting on the severity of his headaches and his inability to perform his duties in the army.

I had no more formal interviews with Pvt. Walden, but shortly after this he came into the Red Cross tent to volunteer for the morning police duty. He proved to be our most efficient and reliable janitor. After he had done a heavy job of carrying coal or splitting wood I asked several times if this did not bring on headaches, but he denied

that it ever did. We frequently had short and informal conversations. He appeared to improve in general health and engaged in various activities around the hospital. Of course, I wondered whether his volunteering for police duty with us was not an expression of his guilt about using his headaches to get out of the army, as he gained understanding of the basis for them.

After Pvt. Walden left for the United States, a copy of our record was sent to the Red Cross Headquarters to be forwarded to the Red Cross Unit of the hospital to which he would finally be sent for treatment and disposition. This unit thus had attention called to the patient and could continue where we left off.

An Unstable Youth

My work with Pfc. Dodge can be used to illustrate the second type of situation in which it had been thought that the social worker might supplement the work of the psychiatrist in individual situations. Pfc. Dodge was 19, having volunteered for service at 16 and falsified his papers. As a child he had been neglected by parents who quarreled constantly. He had run away to an exceedingly strict grandfather, and then had left this home when threatened with being returned to his parents. Since then he had drifted, with no security anywhere. Later he became acquainted with a middle-aged woman, Mrs. Peters, who took him into her home and became the only mother he had known. Dodge was admitted to the hospital in a depressed state. Because of his hostility and marked lack of perseverance it seemed likely that he would be returned to the States. While he remained in the hospital the psychiatrist feared that he might burst out into a hysterical panic on the ward. Since his past indicated that he could form a relationship with a woman, but not with a man, the psychiatrist thought the social worker might work out a supportive relationship with the soldier that would tide him over and prevent an outbreak.

In the first interview the patient's tensions and restlessness were marked, but he talked freely and readily to me, and seemed pleased at the suggestion that he come to my office to talk at regular intervals. He talked first of his battle experiences, but his story was so confused, and he jumped so from one incident to another, that it was impossible to get a clear story. He had been in the "medics"

of a tank destroyer outfit and suffered a shrapnel wound in his head in a battle during the Tunisian campaign the previous spring. At the same time that he was wounded he saw his buddy killed. His lieutenant, of whom he was very fond, was killed also. He stated that after receiving his wound he did not know what happened except that he became hysterical. He found himself in a hospital and later was sent to a replacement center. Then he "took off" without orders and rejoined his old outfit. (Soldiers sent to replacement centers from a hospital frequently did this in North Africa in their anxiety to rejoin their own outfit, and my impression is that it was not considered a serious breach of discipline.)

The patient talked in a disjointed way of unpleasant experiences after his return to his outfit and expressed a great amount of hostility to various officers. After this trouble with his officers he had again been hospitalized, reclassified, and sent to duty at a prisoner-of-war camp, where he was made a laboratory technician. Here he began a correspondence course for college entrance. For a while he got along all right with this, he said, but presently began to get upset, restless, and became unable to concentrate and study. He was not interested in anything, he could not settle himself long enough to study, read, or take part in any activity. He just wandered around the hospital grounds. At the end of the interview he volunteered that he would very much enjoy talking further with the social worker and a future appointment was made.

Pfc. Dodge came in the next day without any appointment. He said he came to see if I could find out whether or not he was going to receive the Silver Star for which he had been recommended. He then told me of the incident in vivid detail, reliving the emotions involved. He had seen one lieutenant buried in a foxhole by artillery fire; ran down the road, under fire himself, got hold of the officer's feet, and pulled him out. This officer was found to be dead. Under him was another man, still alive, whom he was able to save.

The patient came in for five interviews after this. In the third interview he said he was feeling "disgusted," that people were getting on his nerves. He had had only one friend in his life, his buddy who was killed. When he was in the prisoner-of-war camp, the other soldiers used to be sarcastic and called him "psycho." He spoke of his disgust with his fellow soldiers at this camp. All they ever thought of was getting drunk and going to houses of prostitution.

Sometimes he used to go to the Red Cross Club, but the boys would want him to go see Madam So-and-So, and when he refused, they thought that he was not a regular guy. He dated his acute nervousness from the time his friend was killed. He now felt that it was his fault. His friend had been funny and nervous for a few days and did not want to go on this particular mission, but Pfc. Dodge had insisted that they go to pick up medical supplies. They were sitting by the side of an ambulance when he was struck by a shell. Then he turned and saw that his buddy had been hit at the same time and knew that he was dead. It did not bother patient to be hit—in fact, he was glad to be hit; he was just so tired and sick of everything, tired of living in slit trenches and ducking into foxholes. Besides, they had been strafed for 36 days before any of our planes had come over. He had never got over the feeling he had when they were strafed.

During this period the patient recounted to me a number of details about his childhood, talked about his sister who had come to live with him at Mrs. Peters', and for whom he had assumed a good deal of responsibility. I learned that he was engaged to Mrs. Peters' daughter. He was sending $40 a month back to his bank, had $500 saved, and intended to buy a farm. He thought he would feel very much better if he could return to work on a farm for he enjoys this kind of work.

There was no attempt to interpret to the patient any of his feelings as a result of the death of his friend. It was evident that his sense of loss was complicated with a great deal of guilt. It is possible that this was related to some repressed childhood experiences. Whatever the cause of guilt it is evident that it was a transference of feeling from another situation, since in reality he was not responsible for his friend's death, although the fact that he had urged his friend to go on the mission may have provided some realistic basis for these feelings.

I did talk to him about concrete problems. He saw the need for getting interested in something about the hospital, in trying to control his restlessness and to find some useful occupation. He shortly found that he was able to read. Later, on his own request, he was given duties in the hospital laboratory. He was able to see the need for friends and the necessity of controlling his temper. During this time he became much less restless, more relaxed, talked in an orderly,

connected fashion, and became quite cheerful. In his ward there were no outbreaks and he got along well with his ward mates, making a few friends. After I stopped seeing him formally, he began coming into the Red Cross day-room—something he had not done before—and I chatted with him on these occasions.

Because of his background it was not expected that Pfc. Dodge could recover sufficiently to go back into military life. It did appear, however, that he could make a fair adjustment in civilian life. This record, too, was forwarded to the Red Cross back home after he left our hospital, so that the Red Cross there could continue the help he would need.

Here was a boy with an unstable background, yet able to go through the training period and most of the African campaign. He broke down only after a prolonged period of combat and after seeing his one friend killed. In this hospital his greatest need seemed to be that of a sustaining and reassuring relationship that would help bring him back into normal activities.

In this situation, as in innumerable others with which I dealt, there is unique value in talking over recent traumatic war experiences. This is true in very short contacts, even in a single interview. Over and over again I found the healing value to be surprising. Here, with Pfc. Dodge, a relationship was created which could be an assurance and a bulwark against the load of anxiety made active by the death of his friend. Restless and uneasy in a mold in which the frail shell of his compensations had been shattered, his relationship to the social worker provided one source of peace. In conversation with a friendly person, by going over the shattering experiences, he could begin to gain mastery of his feelings of guilt, bewilderment, and whatever else was troubling him, and could again learn to function in a world of reality. The healing process was helped because I was a woman and a member of the American Red Cross, with all the symbolic significance the latter implies.

IN SUMMARY

IN THIS SETTING of a military hospital overseas, the social worker had to function in a medium unlike anything for which her previous experience had prepared her. The usual physical setup and equipment were nonexistent. Elements of distance and difficulties of communication separated her from the accustomed, supporting close presence of an agency and supervision. Far away were the traditional aids of family and social resources. Functioning was severely limited by the short association with patients and by the pressure of the job. The case work tools—understanding and skill—stood pretty much alone and in these situations were put to a severe test of usefulness. But I do not think it can be doubted that at least the simple and concrete steps of case work can be used everywhere in military settings. The greater part of case work in any setting consists of these simple steps.

The objectives of the job were set by the army. They were to help the sick or wounded to return to duty faster, or, if the soldier were to be discharged from the army, to help him become a more productive citizen. If the setting presented difficulties and frustrations, the rewards were commensurate. The traditional function of the social worker in helping the individual now coincided with helping to win the war. No social worker could ask for a greater opportunity.

Overseas the job called for more than professional skills. It called for the involvement of the total personality. The professional and personal self became integrated in the adaptations made in entering overseas service. There were adaptations to be made in the mode of living, in the giving up of privacy, in changing tastes in food, in adjusting to military discipline and the consequent curtailment of personal freedom. All this became symbolized in putting on the Red Cross uniform, which the army never allowed to be taken off for any occasion while the worker was overseas. Out of this pool of adaptations came a sense of freedom in becoming oriented to this strange new world. Out of it, too, came a sense of extended range of capacities.

In this setting and confronted by the pressure of so many human needs, we did whatever we could, employing the total range of personal capacities.